Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PREFERRED IMAGING MEDICAL CENTER
5920 FOREST PARK ROAD
DALLAS, TX 75235-6413

Respondent Name
VANLINER INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-10-0598-01

MFDR Date Received
SEPTEMBER 23, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier has denied payment on code 73700CT of the ankle due to absence of pre-authorization. However, the 3d for obtaining 3 views has been reimbursed. The views we have obtained could have had not acquired without the main procedure which was the CT scan."

Amount in Dispute: $404.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preferred Imaging Medical Center did not obtain express written preauthorization from Vanliner Insurance Company's delegated and licensed preauthorization utilization review agency (Coventry WC Services) prior to rendering the disputed service. Vanliner…bill review and processing agent inadvertently reimbursed Preferred Imaging Medical Center for another billed CPT Code (76376) on this date…Vanliner…has appropriately denied payment for the disputed health care treatments/services billed by Preferred Imaging Medical Center."

Response Submitted by: Vanliner Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2009	CPT Code 73700	$404.69	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197-Precertification/authorization/notification absent.
   - 855-024-Service is denied for lack of proof of pre-authorization.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - 100-Any network reductions in accordance with the network referenced above.
   - 113-001-Network import re-pricing-contracted provider.
   - X973-Pre-authorization not obtained.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Does the documentation support that preauthorization was obtained for the disputed service? Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed service based upon reason codes"45, 100, and 113-001."

   The respondent submitted a supplemental response on December 20, 2010 stating "Neither Vanliner Insurance Company nor its delegated bill review agent possesses a network or 'PPO' contract which was applicable and in force during the above refereed dates of service." Therefore, a contractual agreement issue does not exist in this dispute.
2. The insurance carrier denied reimbursement for the disputed service based upon reason codes "197 and 855-024, and X973."

   28 Texas Administrative Code §134.600(p)(8)(A) states "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   The requestor did not submit a written preauthorization report to support the disputed service was preauthorized in accordance with 28 Texas Administrative Code §134.600. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/15/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787,

Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.